**INSTRUCTIONS FOR UNIFORM BILLING DOCUMENT (Short Form)**
**Not Respite (rev April 2007)**

1. **PROVIDER NAME:** Provider name as contracted with ADES/DDD.
2. **FEI / SSN:** Provider's Federal Employer Identification # or Social Security Number
2a. **PROVIDER NPI NUMBER:** National Provider Identification number of provider.
3. **PROVIDER OF SERVICE AHCCCS ID**: For Therapy Only, enter the providers ID number as assigned by AHCCCS.
4. **MONTH/YEAR OF SERVICE:** The month and year that is being billed. One month per billing document.
5. **SERVICE:** The service that is being billed. One service per billing document.
6. **CONTRACT NUMBER:** The Provider's contract number. The contract number must correspond to the fiscal year that bills are submitted.
7. **DISTRICT:** Circle the appropriate District to be billed for this service.
8. **PROV LOC:** Two letter providers **Location Site Code** where service was delivered. (e.g. AA, AB, etc.)
9. **ASSISTS CONSUMER ID:** This is the ASSISTS consumer identification number assigned by the ADES/DDD.
10. **CONSUMER NAME/LAST:** The consumer's last name.
11. **CONSUMER NAME/FIRST:** The consumer's first name.
12. **SVC START DATE:** First day service was delivered (MM/DD/YY)
13. **SVC END DATE:** Last day service was delivered (MM/DD/YY).
*(If there is a break in consecutive days of service, you need to use a new line)*
14. **SVC CODE:** The three-character code that designates the service authorized and delivered. NOTE: Please use only one service code per page.
15. **P.O.S:** Place of Service code, enter the two digit code that indicates the **type of setting** where the service was delivered.

| TWO DIGIT CODE | TYPE OF SETTING |
|---|---|
| 11 | Office |
| 12 | Patient's Residence (home, ADH, CDH, group home, IDLA, etc) |
| 22 | Outpatient Hospital |
| 31 | Skilled Nursing Facility |
| 32 | Nursing Facility |
| 33 | Custodial Care Facility |
| 54 | Intermediate Care Facility/Mentally Retarded |
| 56 | Psychiatric Residential Treatment Center |
| 99 | Other Unlisted Facility (e.g. park, transportation, store, etc) |

16. **DELIVERED UNITS:** Enter the number of units delivered.
17. **ABSENT UNITS:** This is not functional at this time.
17a. **NO SHOWS:** **Therapy No Shows** have to be billed as a one-half unit at the full rate. For all No Shows, use TPL column 20 and input "**NS**". Use a separate line for each No Show and put 0.5 units for each No Show.

18. **TOTAL UNITS:** Enter the total number of units. This is the total of number 16 and number 17.
19. **RATE:** Enter the contracted rate per unit/hour for the service.
20. **TPL CODE:** Third Party Liability Code, do not fill in. The ADES/DDD representative will complete. NOTE: For all consumers having insurance, you must include an Explanation of Benefits (EOB) that corresponds to the service and date delivered or a waiver.
21. **TPL AMT:** Third Party Liability is the amount paid by insurance companies The third Party Liability Amount that is required is the amount you receive - but only up to the maximum of your contracted rate. For example: if the contracted rate is $70 and the amount you are paid TPL is $100, enter $70 (your contracted rate) in column 21 and the amount to bill the Division is $0.00. If the contracted rate is $70 and the amount you are paid TPL is $50, enter $50 in column 21 and the amount to bill the Division is $20.00.
22. **TOTAL (ROW):** Enter the total dollar amount billed (billed units/hours x rate = total amount) less any TPL if applicable.
23. **SITE RATE COUNT:** Enter the number of individuals sharing the service at common site, and common time. (i.e. RSP 3 persons multiple consumer. rate for each would be 3. Group home will be number of individuals sharing the day. If absent, still include in number. If vacant, don't include in number.)
24. **ADDITIONAL UNITS:** You may bill extra units of service in addition to those for which you have already been paid as long as they are a legitimate claim. This is done by putting an "X" in this column for the appropriate consumer. You cannot use this column if you billed at the wrong rate or for any other purposes.
25. **TOTAL (COLUMN):** Located in the bottom right corner. Enter the total dollar amount of this column for this page only.
26. **CERTIFICATION STATEMENT:** The Preparer and the Provider must certify to the correctness of the invoice by providing signature, date and telephone number.
27. **TOTAL BILLING AMOUNT SUBMITTED UNDER THIS INVOICE:** Enter the total amount of all pages.